MITSS Newsletter

Summer/2006

MITSS Fifth Annual Dinner and Fundraiser to be Held November 9, 2006 at the Seaport Hotel in Boston

Medically Induced Trauma Support Services will hold its Fifth Annual Dinner and Fundraiser on November 9, 2006, from 6:00 pm to 10:00 pm at the Seaport Hotel located on Boston's historic waterfront. We are pleased and proud to announce that Anthony Whittemore, MD, of Brigham and Women's Hospital, and Maureen Bisognano of the Institute for Healthcare Improvement will serve as this year's Co-Chairs. Julie Morath of Children's Hospitals and Clinics in Minneapolis and St. Paul will deliver this year's keynote address.

Dr. Whittemore has been the Chief Medical Officer of the Brigham and Women's Hospital in Boston since 1999, having served as Chairman of both the Medical Staff Executive and Quality Assurance/Risk Management Committees, as well as Director of the multidisciplinary BWH Vascular Center. He served previously as the Director of the Surgical Residency Training Program and Chief of the Division of Vascular Surgery. He has also served as Vice-Chair of the Department of Surgery and is Professor of Surgery at Harvard Medical School. In addition, Dr. Whittemore maintains an active surgical practice.

Maureen Bisognano, Executive Vice President and Chief Operating Officer at IHI, teaches and consults with executive leaders to improve health care systems. Ms. Bisognano has authored articles on leadership and designed methods to help leaders improve performance. She is on the faculty of the Harvard School of Public Health. Prior to Joining IHI, she was CEO of Massachusetts Respiratory Hospital, and she was Senior Vice President of The Juran Institute.

Seaport Hotel, Boston

Julie Morath, RN, MS, is the Chief Operating Officer for Children's Hospitals and Clinics in Minneapolis and St. Paul. Ms. Morath is a nationally known leader in patient safety. She participated in Harvard Executive Sessions on Medical Accident and Patient Safety and was appointed Fellow to the Salzburg Seminars on Patient Safety. The focus of Ms. Morath's work has been on leadership, cultural change, and organizational alignment to create high reliability in health care. She is the author of "The Quality Advantage."

The event will include dinner, a raffle, and a wonderful lineup of great speakers. Look for details to be forthcoming on our website and in upcoming mailings. Please join us for this very important event. Our Fifth Annual Dinner and Fundraiser is a true milestone, and we need your participation to make it our most successful to date. See you at the Seaport!!!

Julie Morath
Keynote Speaker

COO, Children's Hospitals and Clinics, Minneapolis and St. Paul, Minnesota

Anthony D. Whittemore, M.D.
Dinner Co-Chair

CMO, Brigham and Women's Hospital

Maureen Bisognano
Dinner Co-Chair

Executive VP and COO, Institute for Healthcare Improvement (IHI)

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From the Executive Director – *A Call to Action*

The recently released Harvard consensus paper "When Things Go Wrong: Responding to Adverse Events" is a call to action for the healthcare community to come together in a systematic way and do the right thing when adverse medical events occur. Its authors, led by Dr. Lucian Leape, Harvard School of Public Health and MITSS Board Member, put forth a thoughtful and comprehensive approach to dealing with this important and, all too often, neglected issue. Disclosure, apology, and support are highlighted as crucial elements in caring for the emotional needs of patients, their families, and clinicians when medical errors and/or unanticipated outcomes happen. It is a groundbreaking piece of work – one that will inspire great discussion and bring forth much needed change in the ways these events are handled.

In November of 1999, I nearly lost my life as a result of an adverse medical event. At that time, a routine ankle block anesthesia was inadvertently administered to my heart, resulting in a full cardiac arrest. Heroic efforts on the part of the hospital team resulted in my surviving the event. I awoke from the surgery unaware of what had transpired and facing the grueling physical recovery ahead. The anesthesiologist involved in the event had attempted to reach out to me. His efforts, however, were thwarted by the hospital administration's concern about the legal implications around disclosure and apology, and by my family's and care providers' protective stance around my well-being.

I returned home with instructions on how to heal the large incision in my chest. What I did not foresee was the enormous emotional toll that the event would take on me as well as my family members. Later I would learn that the anesthesiologist involved in my care would be dealing with his own difficult emotional recovery. While my physical healing went along smoothly, it became evident that I would need emotional support in the aftermath of my medical trauma.

About a year later, I met with the anesthesiologist involved. Through a series of open and frank discussions, we were able to come to an understanding, a peace, and a friendship. It was at that time that I learned that medical trauma not only negatively impacts patients and families, but clinicians who find themselves on the "sharp end" as well. Clinicians are not supported routinely or uniformly when these events occur. I was fortunate that the physician involved in my case not only apologized, but treated me with honesty, compassion, and respect. This is all too often not the experience of patients and families involved in a medical trauma.

My resolve to change the system that had failed me, my family and the clinicians involved in my care culminated in the formation of MITSS in June of 2002. In its landmark 1999 report "To Err Is Human," the Institute of Medicine reported that as many as 98,000 patients die in hospitals annually as a result of a preventable medical error, a startling number which exceeds motor vehicle accidents, breast cancer, or AIDS deaths. This statistic does not even take into account the scores of people who are harmed but survive, their families, or the health care providers involved. It is the purpose of MITSS to increase awareness, educate, train, and provide support around the issue of medical trauma and its impact on ALL involved.

Unquestionably, the Harvard consensus paper will alert the healthcare community to begin recognizing and addressing the importance of proper and timely response when adverse outcomes occur. This report confirms the tremendous emotional impact on all parties involved in unanticipated outcomes, and provides evidence to support the value of MITSS's purpose. The Harvard report substantiates the foundation of the MITSS Program – that in response to an unanticipated outcome, the best policies include full disclosure, apology, and support.

I have traveled the country speaking to hundreds of patients, family members, and clinicians who have been impacted by adverse medical events. Patients and families want to be treated honestly; wish for a full and heartfelt apology when bad things happen; need assurances that the institution will take steps to ensure that the same thing doesn't happen to someone else; and, must have support, oftentimes in the long term. Clinicians finding themselves on the "sharp end" should have their own emotional needs recognized and addressed at the institutional level. Taking care of our caregivers can only translate into better quality health care for all.

Since my own event in 1999, the medical community has made great strides at preventing unfortunate outcomes. An impressive wave of prevention initiatives has been launched. Even in the safest of systems, though, things can and do go wrong. While transparency and disclosure are goals of the patient safety movement, there still exists a "wall of silence" whereby open and frank dialogue is often discouraged as the fear of malpractice litigation still looms large. We must do better. Honesty, apology, and support – as patients we need to partner in our own healthcare and expect no less.

Linda K. Kenney

Patients First: Massachusetts Hospitals Publicly Post Staffing Plans.

by Karen O. Moore, RN, MS, FACHE

The Massachusetts Hospital Association (MHA) and the Massachusetts Organization of Nurse Executives (MONE) embarked on the Patients First Initiative in January of 2005. Now just 1 year later, all Massachusetts hospitals are publicly posting their staffing plans on the Patients First website, www.patientsfirstma.org

The five components of the Patients First Initiative are:

Providing staffing that meets patients' needs. (Staffing plans that are developed with nurses, publicly posted and evaluated annually)

Promoting a safe and supportive work environment for all those who provide care and in which safety is the top priority. (From board to bedside, a top-down agenda; elimination of mandatory overtime and adoption of best practices)

Provide the public with the hospital performance measures that they need to make informed decisions about their care. (Public reporting of clinical outcomes, including those sensitive to nursing care)

Tackling the chronic problem of shortages of nurses and other caregivers. (Building a plentiful and committed workforce through hospital-based initiatives and strategic partnerships)

Educating the public about what hospitals are doing to ensure and improve safe care. (Forging partnerships among hospitals and with the leaders of education, business, government, consumer groups and others to promote access to high quality, safe care for all).

By posting staffing plans, they are the first in the nation to voluntarily show what types of staff are working on all medical surgical and critical care units. This demonstrates their commitment to patient quality and safety.

The template for the staffing plans was developed by a group of MONE members working with the Massachusetts Hospital Association and Applied Management Systems to develop a tool that could be used by all hospitals regardless of type. With input from these nurses, the tool underwent many revisions before being field tested in July of 2005. The statewide pilot with 100% of hospitals participating was completed in November 2005 in preparation for the final launch in January 2006.

The staffing plans report the amount of care a patient receives in Worked Hours per Patient Day (WHPPD). This is a nationally recognized indicator of the American Nurses Association's (ANA) National Database of Nursing Quality Indicators (NDNQI). The WHPPD numbers can vary from hospital to hospital and even from unit to unit, or from shift to shift. The plans were developed taking into consideration many factors including the severity of the patient's condition, the skill and experience of the nurse, the amount and type of additional members of the care team and the technology that is available to the nurse.

In addition to the staffing plans there is supplemental information on the website, including a consumer brochure (available in Spanish and English) and a section of frequently asked questions which can guide consumers and staff alike to ask questions, should they or a loved one require hospitalization. Two examples are:

Can any conclusion be drawn if the staffing on one unit is higher or lower than another? Direct comparisons like that cannot be made between or across units. Staffing is based on the needs of a particular patient unit and can differ from unit to unit within the same hospital. For example, staffing in an intensive care unit is higher than staffing in a general medical surgical unit because of the critical needs of patients that are in intensive care units. They require more hours of nursing care and close monitoring for changes in condition. Staffing across similar units can also vary based on the experience and education of the registered nurses and the availability of other clinical caregivers, such as therapists. When looking at a staffing plan, it is important to look at the indirect staff who also provides care.

Why do staffing numbers differ from hospital to hospital and unit to unit? Staffing numbers vary because patient care needs differ and can change minute-to-minute, hour-to-hour. Staffing has to be closely watched and adjusted from time to time based on the changes in the needs of the patients.

The plan is based on averages. There are times when more staff will be needed and times less staff will be needed.

Activity on a patient care unit changes constantly and therefore, patient needs change constantly. For example, admissions, transfers and discharges occur on a regular basis, changing the make-up of a unit, or patients may become sicker during a day and need more than expected nursing care.

Nurse staffing is frequently evaluated and readjusted to make sure patients are properly cared for. The staffing plans, therefore, are not meant to compare one hospital to another or one unit to another, but are a planned baseline from which patient care needs are adjusted.

In summary, posting of staffing plans provides consumers with information about the care they can expect to receive if they are admitted to a hospital.

Massachusetts hospitals continue to demonstrate leadership in public reporting and accountability. Next steps in the Patients First Initiative include the public reporting of the actual care delivered when compared to the published plan, with an explanation of any variances ±5%. A pilot of six National Quality Forum (NQF) nursing-sensitive measures is underway, to test the feasibility of measuring these across the state and to inform the selection of at least two measures for further public reporting.

Linda K. Kenney, MITSS Executive Director, Receives NPSF Socius Award

Ms. Kenney accepting the Inaugural Socius Award

Linda K. Kenney, Executive Director of MITSS, was presented with the Inaugural Socius Award at the National Patient Safety Congress held in San Francisco this past Spring. Socius is the Latin word for "partner," and the NPSF Socius Award is given in recognition of work that promotes positive and effective partnering between patients, families, and providers in pursuit of improved patient safety. Ms. Kenney accepted the award, accompanied to the podium by Dr. Rick van Pelt, MITSS Board Chairman.

When queried about her reaction to receiving this prestigious award, Ms. Kenney replied, *"I am grateful to the NPSF for honoring our organization. It is my hope that this wonderful recognition will go a long way towards advancing the MITSS mission of providing support to all those impacted by adverse medical events. We are truly committed to patient safety and to that end pledge to strengthen existing as well as forge new partnerships within the healthcare community."* Ms. Kenney praised the MITSS Board of Directors as well as MITSS staff for their hard work and dedication to the organization.

MITSS Executive Director Graduate of HRET/NPSF Patient Safety Leadership Fellowship

MITSS is pleased and proud to announce that its President and Executive Director, Linda K. Kenney, has recently graduated from the prestigious Patient Safety Leadership Fellowship. This year long Fellowship is sponsored by the Health Research & Educational Trust (HRET) and the National Patient Safety Foundation (NPSF), in partnership with the Health Forum, the American Hospital Association (AHA), the American Organization of Nurse Executives (AONE), the American Society of Healthcare Risk Management (ASHRM), and the Society for Hospital Medicine (SHM).

Linda Kenney has the further distinction of being the first consumer representative to complete the Fellowship. *"HRET and partners have shown a true commitment to patient and family-centered care by having me, a patient advocate, participate in this program. The experience has expanded my knowledge and understanding of the issues surrounding patient safety that will enable me to continue to be an effective partner with health care.,"* Kenney said.

The Patient Safety Leadership Fellowship program is an intensive educational experience that develops leadership skills and advances patient safety issues in health care. Through the program, Leadership Fellows are exposed to a wide variety of tools, strategies, and methodologies in the field of patient safety.

MITSS Announces Three New Board Members

MITSS is pleased to announce that Dr. Lucian Leape, Dr. Eric Knox, and Marten van Pelt have joined its Board of Directors.

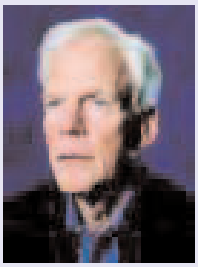
Lucian Leape, MD, is an Adjunct Professor of Health Policy in the Department of Health Policy and Management at the Harvard School of Public Health. Dr. Leape has enjoyed a long and distinguished career and is an internationally recognized expert on patient safety issues. MITSS is extremely fortunate that a member of the medical community of Dr. Leape's stature has joined its board.

Eric Knox, MD, is the former Director of Patient Safety and Risk Management at Children's Hospital Minneapolis. He is a well known researcher and consultant and has published over 100 articles concerning clinical practice and management of clinical risk. When asked about joining the MITSS Board and working with MITSS President Linda Kenney, Dr. Knox replied, *"I very much admire the work you are doing and am honored to have a chance to assist in it."*

Marten van Pelt is currently Marketing Director for Communications & High Tech practice of Accenture, a global business and technology consulting firm. Marten brings a wealth of marketing and business experience to the MITSS Board. His skills and expertise will most certainly complement those of existing MITSS Board Members.

MITSS is very excited about the addition of these three new board members. We look forward with great enthusiasm to their participation in our organization.

Lucian Leape, MD



Eric Knox, MD

Marten van Pelt

The MITSS Story is Now Available on DVD – Order Your Copy Today!!!

The MITSS Story is a documentary about a patient and physician who share an adverse event and chronicles their journey toward healing. Linda Kenney was a patient admitted for an ankle replacement. Dr. Rick van Pelt was the assigned anesthesiologist. No one could have predicted the event that nearly took Linda's life. No one could have predicted the power of their commitment, collaboration, and resolve to change the system which had failed them. It is a story of both pain and hope.

Although this is Linda and Rick's story about what they did in the absence of emotional support, the DVD is intended to stimulate discussion about the current cultural and institutional barriers that exist following adverse medical events around disclosure, apology, and support. Versions of this story happen everywhere – they are not specific to one organization.

The video is 16 minutes long and includes a short facilitator's guide with sample discussion questions and suggested readings on the topics of disclosure, apology, and support.

The MITSS DVD was underwritten by the Dana Farber Cancer Institute and Brigham and Women's Hospital. Blue Cross® Blue Shield® of Massachusetts funded the distribution costs, and there are a limited number of complimentary copies still available to Massachusetts based organizations. Please contact us at (617) 232-0090 for more information.

For organizations and individuals located outside of Massachusetts, MITSS is requesting a tax-deductible donation of $200 for the DVD. All proceeds from the video will be used to fund MITSS programs and further our mission of "Supporting Healing and Restoring Hope" to patients, families, and clinicians impacted by adverse medical events. Give us a call at (617) 232-0090 or visit our website at **www.mitss.org** for a downloadable order form.

MITSS Board of Directors

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Thank you for supporting MITSS